DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LTC Residents Protection
MAY 11 2010
Director's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING _____ B. WING _____	04/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from April 12, 2010 through April 16, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, and review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was 87. The survey sample totaled 32 residents.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**F157** 1. **Resident #151is currently in the hospital.. Current residents with any change in condition have been reviewed for proper physician/family notification and follow up.** 2. **In-servicing shall be held on or before 6/15/10, for licensed nursing staff on physician and family notification of change in condition.** 3. **Random audits shall be completed over the next 90 days for residents with a change in condition to determine compliance. This shall be the responsibility of the DON/designee.** 4. **The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.**	6/15/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan K. Comegys NHA — TITLE: Administrator — (X6) DATE: 5-10-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R151) out of 32 sampled residents the facility failed to consult with the resident's physician regarding a significant change. The facility failed to notify the physician when R151 experienced an elevated temperature. Findings include: The facility's policy and procedure entitled "Physician Notification" was reviewed. R151 was admitted to the facility on 12/9/09 post hospitalization for rehabilitation services. R151 was non verbal and had diagnoses that included fracture of the left upper leg, osteoporosis, profound mental retardation, chronic airway obstruction and asthma. Review of R151's nurse's notes and temperature summary sheets revealed that the resident had elevated temperatures of 99.4 F (axillary) on 12/9/09 at 11:03 PM, 99 F on 12/10/09 at 2:15 AM and 101.1 F (oral) on 12/10/09 at 4:51 PM. There was no evidence that the facility notified the physician regarding these elevated temperatures. On 12/11/09, R151 was seen and examined by the physician for the admission health and physical (H & P). The H & P did not indicate any elevations of R151's temperature and there was no evidence that the physician was notified at that	F 157		

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F 157	Continued From page 2 time. A nurse's note, dated 12/11/09 and timed 10:20 PM, indicated that R151 had an oral temperature of 101.5 F, Tylenol was administered and the temperature decreased to 97.4 F (axillary). The nurse's note stated the resident had a good appetite for dinner and had no signs or symptoms of pain or discomfort. Again, there was no evidence that the physician had been notified of R151's elevated temperature. A nurse's note, dated 12/12/09 stated R151 had a temperature of 100.5 F at 9 PM and after Tylenol was given it dropped to 98.1 F. No other signs and symptoms were noted, nor was there evidence that the physician was notified. On 12/13/09, nurse's notes indicate that R151's temperature was 101.4 F at 8:30 AM. Tylenol was administered, however once again the physician was not notified. At 1:00 PM on 12/13/09, the nurse's note stated R151 was diaphoretic (sweaty) and her temperature was 102.1 F. Tylenol was administered and the physician was finally notified and ordered a chest x-ray, urinalysis (UA) and urine culture and sensitivity (C & S). R151 was found to have a urinary tract infection. The facility failed to notify the physician regarding R151's elevated temperatures in a timely manner. In an interview with E2 (Director of Nursing) on 4/16/10, she acknowledged the findings.	F 157		
F 241 SS=B	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

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F 241	Continued From page 3 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based upon observation and interview it was determined that the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect during the dining experience for 3 (R112, R116 and R142) out of 32 Stage II sampled residents in relation to clothing protectors. Additionally, in the restorative and the dayroom at the nurses' station, all residents were served and their food remained on the trays. Finding include: 1. During a lunch observation on 4/12/10 at 12 PM in the restorative dining room, E10 (CNA) was observed placing a clothing protector on R112 without first asking permission. 2a. During the same lunch observation on 4/12/10 at approximately 12:05 PM, E10 (CNA) attempted to place a clothing protector on R142 without first asking if she wanted one. R142 refused to have the clothing protector applied. b. During a dinner observation on 4/15/10 at approximately 4:50 PM in the restorative dining room, R142 was observed having a clothing protector placed by E12 (CNA)without first asking the resident if she wanted it. E12 stated during interview on 4/15/10 at 5:10 PM that she was supposed to ask the resident if she wanted to use a clothing protector before applying one. 3. During the same dinner observation on	F 241	**F241** 1. **All residents identified remain in the center and are having their dignity protected by being asked if they would like clothing protectors used during meals. Current residents have been observed before meals to determine no others are affected.** 2. **In-servicing shall be completed on or before 6/15/10, for all staff on resident rights and dignity.** 3. **Random rounds shall be completed over the next 30 days to determine compliance; this shall be the responsibility of the Social Services Director/designee.** 4. **The Social Service Director shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.**	6/15/10

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F 241	Continued From page 4 4/15/10, R116 was interviewed and stated that he was not asked if he wanted a clothing protector on. He further stated that it was just placed on him and he did not think that he needed it. R116's clothing protector remained clean throughout the meal. During dining observations on 4/12/10 at the mid-day meal and on 4/15/10 at the evening meal, residents in the assisted and restorative dining areas were served meals on trays and ate their entire meals from their trays. Service in the main dining room differed in that residents there had their plates removed from their trays and placed on the dining tables.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		

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F 279	Continued From page 5 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R13 and R14)) out of 32 sampled residents the facility failed to develop a comprehensive care plan for an identified resident care area. R13's care plan for anxiety failed to include behavior monitoring and the pharmacological intervention. R14's care plan failed to address anxiety and the behavior monitoring for this care area. Findings include: 1. Record review revealed that R13 was admitted to the facility on 1/11/08 and was receiving Xanax every day for anxiety related to her medical conditions. A care plan was implemented on 1/11/08 and still active for anxiety, however, the care plan failed to include the monitoring for the behavior symptom. In addition, the care plan failed to include the pharmacological intervention as well as the potential side effects of the medications. An interview with the Director of Nursing (E2) on 4/16/10 at 1 PM confirmed the findings. 2. R14 had diagnoses which included Alzheimer's dementia with delusions, depression and generalized anxiety disorder. The resident was receiving an anxiety medication, Klonopin 0.5 mg tid (3 times a day), for anxiety. The resident was being monitored for a behavior of crying for no apparent reason. According to interviews with nurses E2 , E3 and E6 it was revealed that the crying was a sign of anxiety. Although R14's care plan did address the	F 279	**F279** 1. Resident #13 and 14 have been reviewed by the Interdisciplinary Care Plan (ICP) team and the plans of care has been reviewed and corrections have been made as necessary to meet the resident's current level of care. Behavior monitoring has been put in place to monitor behaviors related to medication use for resident # 13. New and current residents shall be reviewed by the ICP team at the next scheduled care plan meeting to determine accuracy of their plans of care. 2. In-servicing shall be held for the ICP team and nursing staff on or before 6/15/10, on care planning and changes in condition. 3. Random audits shall be completed over the next 90 days to determine compliance with accurate care plans; this shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances	6/15/10

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F 279	Continued From page 6 depression and psychosis it lacked any indication that the resident had anxiety and was being monitored for behaviors related to anxiety.	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that adequate monitoring of medications was done for two (R13 and R59) of 32 sampled residents. The facility failed to provide necessary lab testing for	F 329	**in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.**	

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F 329	Continued From page 7 both residents for medications they were receiving. Additionally, the facility failed to monitor behaviors for R13 for a psychoactive medication. Findings include: 1a. Review of R13's April 2010 monthly physician's order sheet (POS) noted that R13 was receiving Lasix (a diuretic) 40 mg. by mouth daily. Record review revealed that the last serum electrolytes were completed on March 3, 2009 and this finding was confirmed with the ADON (E3) during an interview on 4/15/10 at approximately 11 AM. Interview with the attending physician (E8) on 4/19/10 at approximately 12 noon revealed that for R13, serum electrolytes should have been monitored every three to four months. 1b. Review of facility's policy titled "Behavior Monitoring" indicated that residents taking psychotropic medication will be monitored for episodes of behavior symptoms, interventions tried, the outcome of intervention, and any side effects on the behavior monitoring form. Review of R13's April 2010 monthly physician's order sheet (POS) noted that R13 was taking Xanax (a psychoactive medication to treat anti-anxiety) .25 mg. by mouth daily for anxiety. An interview with the assigned certified nursing aide (E9) on 4/14/10 at 2 PM revealed that she was not monitoring any behaviors for R13 since if there were behaviors to be monitored by the CNA's, a behavior monitoring form would have be initiated. An interview with the ADON on 4/15/10 at approximately 10:50 AM revealed that behavior symptoms related to R13's anxiety were not being monitored, however, she stated that a behavior monitoring form would be initiated on this date.	F 329	**F329** **1. Resident #13 has had behavior monitoring put in place for the use of Xanax. Resident #13 and #59 have been reviewed by the consultant pharmacist and recommendations have been given to the primary care physician for lab studies needed. The primary care physician has reviewed the recommendations and has acted appropriately and provided documentation in the clinical record. Current residents with orders for antipsychotic medications have been reviewed to determine the need for behavior monitoring. An audit has been completed by the consultant pharmacist for current residents and any need for lab studies has been reported to the primary care physicians for follow up.** **2. In-servicing shall be held on or before 6/15/10, for licensed nursing staff on antipsychotic medications and monitoring for the need for the medication, and medications requiring lab studies.** **3. Random audits shall be completed weekly to determine compliance over the next 90 days; this shall be the responsibility of the DON/designee.** **4. The DON shall report monthly to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.**	6/15/10

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F 329	Continued From page 8 2. Review of R59's medication regimen revealed the resident was receiving Lipitor 10 mg by mouth daily for elevated blood lipids. The clinical record lacked evidence of a recent blood lipid profile. The last lipid panel was found to have been drawn on 4/1/08. The facility failed to monitor the effectiveness of the Lipitor for R59. During an interview with E11 (nurse) on 4/16/10 at 10:24 AM, she acknowledged the lack of a recent lipid profile for R59. Additionally, an order was written for R59 to have a lipid profile drawn on 4/20/10. The manufacturer's package insert states that "periodic testing of a fasting lipid panel to determine goal attainment" is part of patient counseling information (http//www.pfizer.com/files/products/uspi_lipitor.pdf).	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334		

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F 334	Continued From page 9 documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5	F 334	F334 1. **Resident # 103 remains in the center and has been again offered pneumococcal vaccine; the vaccine was administered on 4/16/10. The appropriate documentation is located in the clinical record. Current residents who have previously refused have again been offered the vaccine and the documentation of acceptance or refusal is located in the clinical record.** 2. **In-servicing shall be completed for licensed nursing staff on or before 6/15/10 on the centers current immunization policy.** 3. **Random audit shall be completed over the next 90 days to determine compliance.** 4. **The DON shall report monthly any variances in the data collected to the Administrator and QA committee. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.**	6/15/10

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F 334	Continued From page 10 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, it was determined that the facility failed to re-offer the pneumococcal vaccination to one (R103) of five sampled residents. Findings include: R103 was admitted to the facility on 9/24/07. At the time of admission, R103 was offered a pneumococcal vaccination, which the resident refused. Record review lacked evidence that R103 was re-offered the pneumococcal vaccination since her refusal at the time of admission in 2007. An interview with the Director of Nursing (E2) on 4/16/10 at approximately 1 PM confirmed that the resident was not offered the vaccination since admission.	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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FORM APPROVED
OMB NO. 0938-0391

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F 428	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that during the monthly drug regimen review irregularities and lack of monitoring were reported to the attending physician for two (R13 and R59) of 32 sampled residents. Findings include: Cross refer F329 example #1. Review of R13's April, 2010 monthly physician's order sheet (POS) noted that R13 was receiving Lasix (a diuretic) 40mg. (milligrams) daily. Record review revealed that the last comprehensive metabolic panel (CMP) to monitor R13's electrolytes was completed in March 3, 2009. There were no recent electrolytes during the monthly drug regimen. On 4/16/10 at approximately 11 AM, an interview with the Assistant Director of Nursing (E3) confirmed no additional CMP had been completed since March 3, 2009. On 4/16/10 at approximately 11 AM, an interview with the licensed pharmacist (E4) revealed that her recommendation would have been for the monitoring of electrolytes every three to six months, however, this was not identified as an irregularity during the monthly drug regimen review. This resulted in a failure to report the lack of monitoring of electrolytes for R13 to the physician. Cross refer F329, example #2 2. Review of R59's MRR (Medication Regimen Review) revealed that the facility's consultant pharmacist failed to identify that R59 was not having lipid profile blood work monitored while receiving the medication Lipitor.	F 428	**F428** **1. Resident #13 and #59 have been reviewed by the consultant pharmacist and recommendations have been given to the primary care physician for lab studies needed. Resident #13 was transferred to Christiana Hospital on 4/18/10 and lab studies were completed there. Labs were repeated here on 4/27/10. Lab studies were conducted on resident #59 on 4/20/10. An audit was completed by the consultant pharmacist for current residents and any needed lab studies has been reported to the primary care physicians for follow up.** **2. In-servicing shall be held on or before 6/15/10, for licensed nursing staff on medications requiring lab studies.** **3. Random audits shall be completed weekly to determine compliance over the next 90 days; this shall be the responsibility of the DON/designee.** **4. The DON shall report monthly to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.**	6/15/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING _____ B. WING _____	04/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 12 During an interview with E6 (nurse) on 4/16/10 at 10:50 AM, she acknowledged that the MRR failed to identify the lack of periodic lipid profiles.	F 428		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085025	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 4/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined that the facility failed to accurately code the Minimum Data Set (MDS) assessments for three (R142, R89 and R13) out of 32 sampled residents. Findings include:

1. Review of the 11/11/09 MDS assessment for R142 indicated that the resident exhibited sad, pained, or worried expression, up to 5 days a week. This was coded as a 1. A significant change MDS was completed on 02/01/2010 that indicated an increase in the behavior for R142, as daily or almost daily. This was coded as a 2. Follow-up interviews with E1(NHA) and E5(RNAC) indicated that the facility had discovered that the coding for this particular section of the MDS had been done incorrectly and that the section of the MDS in question should have been coded as a 0. This would have been defined as not exhibited in the last 30 days.

2. Review of R89's MDS assessment dated 10/20/09 revealed R89 had impaired vision without visual appliance. Observation of R89 on 4/14/10 at 1 PM and on 4/15/10 at approximately 11 AM revealed R89 with eye glasses. Interview with R89 on 4/15/10 at 1 PM revealed that she did not recall misplacing her glasses in October, 2009. A telephone interview with R89's responsible party on 4/14/10 at approximately 12:30 PM revealed that she did not recall R89 missing glasses in October 2009. An interview with the facility's Registered Nurse Assessment Coordinator(RNAC) (E5) who coded the above information on 4/15/10 at 1:30 PM revealed that the above MDS was inaccurate since R89 had corrective glasses during the assessment period.

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085025	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 4/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	Continued From Page 1 3. Review of R13's MDS assessment dated 4/1/10 indicated that R13 exhibited sad, pained, worried facial expression daily to almost daily. Interview with the social worker (E7) who coded the above information revealed that he coded based on the fact that R13 was receiving routine anti-anxiety medication on a daily basis and not based on the actual presence of the above moods.

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: April 16, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from April 12, 2010 through April 16, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, and review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was 87. The survey sample totaled 32 residents.	Please refer to CMS 2567 survey report
3201	**Skilled and Intermediate Care Nursing Facilities**	Substantial Compliance on or before 6/15/10.
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**	

Provider's Signature [signature] Title Administrator Date 5/10/10

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STATE SURVEY REPORT

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: April 16, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	This requirement was not met as evidenced by: Cross refer to CMS 2567-L survey report date completed 4/16/10, F157, F241, F278, F279, F329, F334, F428.	